STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315B CURT DRIVE CHAMPAIGN, IL 61820

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S 000	Initial Comments Incident Report Investigation to Incident of 2/15/16 (IL83614)	S 000		
S9999	Final Observations Surveyor: Larsen, Kimberly STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically

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S9999	Continued From page 2	S9999		

defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review the facility failed to implement preventative fall interventions and failed to maintain effective fall interventions for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 incurring a fracture of cervical fourth and fifth spinal vertebrae.

Findings include:

The February 2016 Physician Order Sheet documents R1 was admitted to the facility on 10/6/15 with diagnoses to include Dementia, Insomnia and History of Falls.

The Minimum Data Set (MDS) dated 11/23/15 documents R1 with severe cognitive impairment. This MDS, Section G0300, Balance During Transitions and Walking is scored, after observation of reviewer, as not steady and only able to stabilize with staff assistance. The Care Area Assessment Summary dated 11/23/15 documents, "(R1) is at high risk for falls due to balance issues, staff will observe and assist with

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S9999	Continued From page 3	S9999		

all transfers ensuring he has his balance before moving."

R1'sCare Plan for falls dated 10/6/15 documents reasons R1 is at risk for falls including R1 is known to attempt to get up from chair unattended. Interventions placed include use of a personal fall alarm on 11/15/15, application of anti-rollback wheelchair brakes to R1's wheelchair on 11/13/15, and on 11/25/15 the anti-rollback wheelchair brakes were discontinued to the wheelchair secondary to improved posture while in chair.

Interview with E3 (Director of Nursing) on 2/25/16 at 12:45pm and review of the facility Incident Log and Situation Background Assessment and Request Forms (SBAR), October 2015 through February 16, 2016, identified R1 with falls without injuries on 10/13/15, 10/20/15, 11/13/15, 11/15/15, 11/25/15, 11/28/15, 12/14/15, 12/16/15, 12/18/15, 12/29/15, 1/4/16, 1/8/16. There were falls with injuries on 1/21/16 (steri strips for forehead abrasion) and 2/15/16 (Fracture of the cervical spinal fourth and fifth vertebrae).

On 2/25/16 at 12:45pm E3 stated R1 was found on the bedroom floor after falling on 11/25/15 by E6 (Nursing Assistant). On 2/25/16 at 1:59pm, E6 stated R1 was supposed to have a personal fall alarm on but at the time E6 discovered R1 on the floor an alarm was not sounding.

The SBAR dated 12/14/15 documents R1 was found on the floor in front of the recliner. On 2/25/16 at 12:45pm E3 stated R1 got up unassisted and was found on the floor by E7 (Nursing Assistant) after a fall on 12/14/15. On 2/25/16 at 2:04pm, E7 stated when E7 entered the room and found R1 the personal fall alarm

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S9999	Continued From page 4	S9999		

was not sounding. On 2/25/16 at 2:28pm, E3 stated R1's personal fall alarm was to be utilized both in bed and in the chair.

The SBAR dated 1/4/16 documents, "(R1) tried to stand on own and fell to the floor on bottom." On 2/25/16 at 12:45pm E3 stated when a fall occurs the resident is to be evaluated for a new intervention to prevent further falls. E3 confirmed E3 was the manager who monitors and analyzes falls and an evaluation for an intervention was not done after the 1/4/16 fall.

The SBAR dated 1/21/16 documents R1 as standing up in the hallway and lost balance causing R1 to fall to the floor. The January 2016 Physician Order Sheet documents an order, "1/22/16 PT (Physical Therapy) to evaluate and treat: frequent falls." E3 stated R1 fell from the wheelchair and after this fall a physical therapy evaluation was ordered. E3 further stated, "It doesn't appear (R1) was evaluated." On 2/25/16 at 2:45pm, E8 (Physical Therapist Assistant) stated R1 was last evaluated and treated in November 2015.

The SBAR dated 11/13/15 documents R1 had his head laying on the dining room table asleep when the wheelchair wheel went back and R1 fell to the floor. On 2/25/16 at 12:45pm E3 stated the anti-rollback wheelchair brakes were added after this fall because E3 was leaning forward in the chair at the time of this fall. E3 stated the anti-rollback wheelchair brakes lock the wheelchair wheels so the wheelchair does not roll back when a resident stands up but when a resident sits down the wheelchair is not locked. E3 stated the anti-rollback wheelchair brakes were removed on 11/25/15 after R1's posture improved with therapy. E3 stated a formal

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S9999	Continued From page 5	S9999		

assessment is not completed for the reduction of preventative fall devices. A review of October and November 2015 Physical Therapy notes did not identify R1 with inadequate posture while seated. Physician Progress Notes, Nurse's Notes and Care Plans, October 2015 through February 2016, did not identify R1 with inadequate ability to sit in wheelchair safely or with inadequate posture while sitting in a wheelchair. The Fall Risk Assessment dated 11/25/15 and 1/22/16 documents R1 at high risk for falls due to cognitive deficits, loss of balance while walking and standing, and requiring assistance to stand; loss of sitting balance is not marked as a deficit for R1. The Physician Order Sheet November 2015 documents a discontinuation of physical therapy on 11/11/15.

The SBAR form 2/15/16 documents at 4:20pm E5 (Nursing Assistant) saw R1 fall. R1 had a red "bump" on the right side of the forehead and R1 was unable to recall how he fell. R1 is documented as sent to the emergency room for evaluation.

The (2-15-16) handwritten statement, completed by E5 documents, "(R1) trying to reposition himself back in his chair, while trying to do so chair when backward and (R1) fell onto the floor on (R1's) right side hitting (R1's) head..."

The Quality Assurance Fall Analysis form dated 2/15/16 documents R1 was witnessed attempting to scoot himself back in the chair when R1 pushed up on the arms of the wheelchair the wheelchair rolled back.

On 2/25/16 at 2:21pm, E5 stated E5 was assisting another resident when E5 seen R1 trying to scoot back in the wheelchair and the

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S9999	Continued From page 6	S9999		

wheelchair went backwards, behind R1 causing R1 to fall and hit head on the floor. E5 stated the wheelchair brakes were not locked when R1 fell.

On 2/25/16 at 2:45pm, E8 Physical Therapy Assistant stated R1 was not able to stand independently, had poor cognition and would try to rise from the wheelchair unassisted. E8 stated anti-rollback wheelchair brakes prevent the wheelchair from rolling back to prevent residents from falling.

On 2/25/16 at 2:04pm, E7 Nursing Assistant stated R1 would frequently attempt to stand up while holding onto the dining room table. E7 stated when R1 was at the table wheelchair brakes were kept locked to keep the wheelchair from rolling back. On 2/25/16 at 2:28pm, E3 stated R1 was able to unlock brakes.

R1's Computerized Tomography (CT) Cervical Spine report dated 2/15/16 documents the indication for completion of this test is back pain after falling out of a wheelchair. The impression documents, "Acute fracture at the C4-5 (Cervical Vertebrae).....with displacement..."

On 2/25/16 at 2:50pm, Z1 (R1's Physician) stated R1 was impulsive with actions and due to dementia R1 had poor safety awareness. Z1 stated she was not aware of the number of falls R1 incurred since admission to the facility but confirmed R1 had a fall 2/15/16 which resulted in a fracture of R1's cervical spinal fourth and fifth vertebrae. Z1 stated she didn't recall being notified the anti-rollback wheelchair brakes being removed from R1's wheelchair. Z1 stated she could not state if it was incorrect or correct for the facility to remove the anti-lock wheelchair brakes despite R1 frequently attempting to rise from the

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S9999	Continued From page 7 wheelchair unassisted and incurring falls from the wheelchair for this reason. The facility's Fall Prevention policy, revised 9/3/15, states the facility is "to provide for resident safety and to minimize injuries related to falls...If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident...All falls are reported and discussed during the morning Quality Assurance meetings and any new interventions will be written on the care plan...Fall prevention interventions include personal alarm, pressure alarm for bed/chair, and Physical therapy referral." (A)	S9999		

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IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Illini Heritage Rehab and HC

DATE AND TYPE OF SURVEY: Incident Report Investigation of 2/15/16 conducted February 25, 2016

300.610a)
300.1210a)
300.1210b)
300.1210d)6)
300.1220b)2)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This will be accomplished by:

I. The facility will conduct assessments of all residents identified as high risk for falls. The care plans of all residents identified as high risk for falls will be reviewed for appropriate fall interventions and revised as needed. All resident incident reports of falls will be reviewed for root cause and appropriate interventions based on the root cause will be developed, care planned, and implemented. The facility will evaluate their method of communicating resident supervision and safety needs to staff and make revisions, as necessary, based on this evaluation.

II. All staff will be in-serviced on supervision of residents at high risk for falls, the facility's fall prevention policy, and the use of personal alarms. The in-service will cover a review of the deficiency and address interventions that would have prevented or diminished the resident's injury.

III. The Director of Nursing and/or designee will monitor and oversee staff to ensure they are following facility policies; that all resident supervision and safety needs are accurately assessed, care planned, communicated, and implemented in a timely manner; and all direct care staff are proficient in the use of personal alarms.

IV. Documentation of in-service training, assessments, and related follow-up actions will be maintained by the facility.

V. The Administrator and Director of Nurses will monitor Items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 10 days of receipt of this notice.

3/17/16/lo

Attachment B
Imposed Plan of Correction